RYAN WHITE TITLE I NUTRITIONAL ASSESSMENT LETTER FOR FOOD BANK SERVICES

(THIS DOCUMENT IS TO BE COMPLETED BY AN INDEPENDENT PHYSICIAN OR A REGISTERED DIETITIAN NOT ASSOCIATED WITH THE TITLE I FOOD BANK PROVIDER.)

TO BE COMPLETED BY PHYSICIAN

Date: _____

As the **primary medical caretaker** for _____, who has a diagnosis of _____, it is my professional opinion that he/she requires food bank assistance.

Please specify frequency:

☐ Weekly ☐ Monthly

Please specify maximum number of additional food bank visits [the provision of this service will be limited to twelve (12) occurrences recommended within the Ryan White Title I fiscal year. One (1) occurrence is defined as all food bank services provided within one (1) calendar week, which starts with the date of the client's first visit to the food bank (first occurrence)]:

☐ One visit ☐ Two visits ☐ Three visits

This assistance will maintain the patient's health by providing a balanced, adequate diet, which the patient is currently not receiving.

Physician Signature_____ Name_____

Print MEO#_____

OR

TO BE COMPLETED BY REGISTERED DIETITIAN

Date: _____

As a **registered dietitian** who has completed an assessment of _____, who has a diagnosis of _____, it is my professional opinion that he/she requires food bank assistance.

Please specify frequency:

☐ Weekly ☐ Monthly

Please specify maximum number of additional food bank visits [the provision of this service will be limited to twelve (12) occurrences recommended within the Ryan White Title I fiscal year. One (1) occurrence is defined as all food bank services provided within one (1) calendar week, which starts with the date of the client's first visit to the food bank (first occurrence)]:

☐ One visit ☐ Two visits ☐ Three visits

This assistance will maintain the patient's health by providing a balanced, adequate diet, which the patient is currently not receiving.

RD Signature_____ Name_____

Print

RD License #_____

Please note: All questions should be addressed to Mr. Daniel T. Wall, Assistant Director, Office of Strategic Business Management, at (305) 375-4742. Requests for information/clarification of a clinical nature will be forwarded by Miami-Dade County to the Miami-Dade HIV/AIDS Partnership Medical Care Subcommittee and/or a qualified member of the Subcommittee (physician, nurse, registered dietitian, etc.).

Pursuant to Article VI, Section 6.4 (H) of the Ryan White Title I service agreement, Miami-Dade County has the right to access all client files (including electronic files), service utilization data, and medical records during on-site verification or audit by County personnel and/or authorized individuals to confirm the accuracy of all information reported by the service provider.